Rhode Island Executive Office of Health and Human Services
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Docket # 15-424
Hearing Date: April 16, 2015

Date: June 11, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you upon a de novo (new and independent) review of the full record of hearing. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0352.15 ELIGIBILITY BASED ON DISABILITY

The facts of your case, the Agency rules and regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page.

Copies of this decision have been sent to the following: You (the appellant), and Agency representatives: Julie Hopkins RN, Carol Cannal, and Gail Scudieri.

Present at the hearing were: You (the appellant), and Jennifer Duhamel, RN (Agency representative).

EOHHS RULES AND REGULATIONS:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

ISSUE: Is the appellant disabled for the purposes of the Medical Assistance Program (MA)?

TESTIMONY AT HEARING:

The Agency representative testified:

- In order to be eligible for Medical Assistance (MA) an applicant must be either aged (age 65 years or older), blind, or disabled.
- The Medical Assistance Review Team (MART) determines disability for the MA program.
- The MART is comprised of public health nurses, a social worker and doctors specializing in internal medicine, surgery, psychology and vocational rehabilitation.
- To be considered disabled for the purposes of the Medical Assistance Program, the appellant must have a medically determinable impairment that is severe enough to render her incapable of any type of work, not necessarily her past work. In addition, the impairment must last, or be expected to last for a continuous period of not less than twelve (12) months.
- The MART follows the same five-step evaluation as SSI for determining whether someone is disabled.
- The MART reviewed two Agency AP-70 forms (Information for the Determination of Disability), a claim letter from her disability insurance company, and records of Anchor Medical.
- They requested records from Blackstone Orthopedics, and West Bay Orthopedics, but none were available from either source for the dates requested.
- She had been denied RSDI eligibility.
- A review of the available records revealed diagnoses of benign hypertension, chronic low back pain, lumbosacral radiculitis, depressive disorder, generalized anxiety disorder, and obesity.
- Lumbar radiculitis is an inflammation of nerve roots that results in pain, and pain medications were being prescribed by Dr Appenfeller.

- Within the records, there were no referrals to physical therapy or pain management centers.
- Reports of pain and side effects of pain medication were taken into consideration.
- Blood pressure was stable, and she was attempting to lose weight.
- Obesity was considered alone as well as in combination with other impairments.
- There were no orthopedic or neurosurgery consult notes included with Dr Appenfeller's records.
- The most recent objective examination note was dated June 4, 2014.
- She was in moderate distress and discomfort.
- While ambulation was noted to be limited there were no specific descriptions of the type of gait or ambulation observed.
- There was no indication that she used any assistive devices.
- There was tenderness along the thoracolumbar region of the spine.
- No diagnostic testing such as x-ray or MRI was ordered.
- In early 2014 she was prescribed anti-depressant and anti-anxiety medications.
- The initial response to the medication was positive, although changes were made without explanation.
- There were no referrals to any mental health agencies for counseling.
- There was no objective evidence relative to mental status or effects of the prescribed medications.
- The records did provide information about limitations of spine mobility, refills and follow up for pain medication, and attempts to reduce weight.
- The MART determined that her chronic low back pain was severe, and continued the sequential evaluation of that condition.
- The impairment did not meet or equal any of the Social Security listings.

- They completed a residual functional capacity assessment, finding that based on the medical records reviewed, she could be expected to perform light work activity.

- As her past relevant work met the requirements for light work, they stopped at step four with a finding that she was not disabled.

- She was not disabled for the purpose of the Medical Assistance program.

The appellant testified:

- She is currently unemployed.

- She was unable to get updated diagnostics because she cannot afford to purchase health insurance.

- Throughout the past year, she has been paying out of pocket for her care.

- She eventually learned that there was care available through a free clinic.

- She had a tumor in her intestines for about one year.

- She was losing weight because she was unable to eat normally.

- She has not worked since June 2011.

- She had applied for insurance under the Affordable Care Act (ACA), but could not afford the premium she was quoted.

- She was forced to move to a less expensive apartment.

- She was covered by Community Free Care through Lifespan for the surgical procedure she needed to address intestinal prolapse.

- She is covered until October.

- Her daughter had kidney cancer in 2013, and she ran up credit cards for her medical care.

- She was found disabled by a private insurance company, and receives a monthly benefit to compensate for her loss of income.

- That unearned income has been counted against her when trying to qualify for reduced health insurance premiums.
- She suffers from Achilles tendon nerve damage (4 years duration), which limits her ability to stand.
- She lost her health insurance in 2012 when her daughter turned 18.
- She has no medical records more recent then 2012 from West Bay Orthopedics.
- She had not applied for Social Security at that point in time, because she believed she would eventually return to work.
- She has not completed any physical medical consultative examinations for her Social Security case, but they did arrange for her to see a psychiatrist.
- She has access to a lawyer through her disability insurer.
- Her back pain continues to limit her, and her physician recommended a spinal fusion.
- She would like to get a second opinion because there has been a change in the location (left to right) of the pain she experiences.
- She has pain across her lower back which radiates into both legs.
- She has been delayed in pursuing a second opinion because she had to address the intestinal problem first.
- In March 2015 she had surgical resection of the intestine completed.
- She still has some follow up pending with the gastrointestinal surgeon.
- She still gets contractions, which the gastroenterologist thought was nerve related, and would improve as she healed.
- She cannot consider other surgical procedures for about six months.
- She had diagnostic images completed which revealed degenerative disc disease and spinal stenosis.
- A recent CT scan showed compression of the spine.

- She was missing the physician examination report at the time of application, but had a new copy completed by her primary care provider which she requested to submit as evidence.

- Her last MRI studies of the foot and back were ordered by Dr Mechrefe (West Bay Orthopedics and Neurosurgery) and completed in February 2012.

- The information that she has hypertension is incorrect, as her blood pressure increases occur secondary to escalation of anxiety.

- She has added fluoxetine for anxiety and bupropion for depression to her medication regimen after the exhibit #4 medication list was printed.

- She has not yet experienced any improvements in symptoms from the new medications.

- Last year she experienced increased anxiety over unexplained weight loss associated with the intestinal disorder which was eventually diagnosed and surgically corrected.

- For a long time, she was attempting to deal with depressive symptoms "naturally", and avoiding medical treatment of the condition.

- She was seeing a counselor for about two years, but the counselor moved away from the area in June 2014.

- She noted on her second AP-70 form that she was dealing with bipolar disorder, ADHD, narcolepsy, sleep apnea, and premenstrual dysphoric disorder (PMDD).

- Her physical conditions have adversely impacted her mental stability.

- She was hospitalized several times as a child, and learned of those conditions over time.

- Dr Appenfeller has been her PCP for fifteen years, and she thought he would have all of the records establishing diagnoses of her conditions, but recently learned that he did not have everything from the past.

- She does not believe she can walk or stand for more than ten minutes because pain increases in intensity.

- For the past three years she has spent much time in bed.

- Her back pain started ten years ago after a motor vehicle rollover accident in which she broke both legs and landed upside down.
- She returned to work after four weeks, despite severe pain.
- She still has knee damage from that incident.
- If she tries to stand to cook or wash dishes, her heel pain quickly interferes (within ten minutes) with her ability to remain standing.
- Sitting is uncomfortable and hurts her back.
- Pain interferes with her ability to complete her personal care, so she does things such as dressing and grooming less often.
- She has been neglecting housework such as vacuuming, dusting, and dish washing.
- She finds that her pain affects her memory and concentration.
- Impact on cognitive functioning was evaluated by the free clinic she attended.
- She becomes irritable and impatient with others because of her constant pain.
- She has told her doctor that she is always "ready to snap".
- Neither the anti-anxiety medication, nor the pain medications provide adequate relief.
- She may need to return to physical therapy which she had postponed due to intestinal surgery and recovery.
- She sees her PCP every month, and there should be new records since the June 2014 notes in the agency file.
- She also has surgical records at Rhode Island Hospital; follow up with the surgeon Dr Choa at the Fain Clinic, and a CT scan and psychiatric evaluation at the RI Free Clinic.
- She requested to hold the record of hearing open for the submission of additional evidence.

FINDINGS OF FACT:

- The appellant filed an application for Medical Assistance (MA) on October 31, 2014.
- The Agency issued a written notice of denial of MA dated January 15, 2015.
- The appellant filed a timely request for hearing received by the Agency on February13, 2015.
- The appellant requested to submit a note dated February 13, 2015 from Rex Appenfeller, MD (exhibit #1), an updated Agency AP-70 form (exhibit #2), an Agency MA-63 form dated February 23, 2015 and signed by Rex Appenfeller, MD (exhibit #3), and a medication history (appellant exhibit #4).
- Per the appellant's request, the record of hearing was held open through the close of business on May 14, 2015 for the submission of additional evidence from Rhode Island Hospital, University Surgical (Dr Choa) at Fain Clinic, RI Free Clinic, and Anchor Medical (Dr Appenfeller).
- At the close of business on May 14, 2015, no additional evidence had been received, and the record of hearing was closed.
- The appellant is not engaging in substantial gainful activity.
- The appellant has not met her burden of proof relative to establish that alleged impairments continue to result in more than a minimal impact on functional capacity as required to perform basic physical work activities.
- The appellant is not disabled as defined in the Social Security Act.
- The appellant is not disabled for the purposes of the Medical Assistance Program.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD:

The record of hearing consists of:

- ✓ An Agency AP-70 dated February 9, 2014 and signed by the appellant.
- ✓ An Agency AP-70 dated October 29, 2014 and signed by the appellant.
- ✓ An Agency AP-70 dated February 2015 and signed by the appellant.
- ✓ An Agency MA-63 form dated February 23, 2015 and signed by primary care physician (PCP) Rex Appenfeller, MD
- ✓ A Long Term Disability claim letter from Unum Benefits Center.
- ✓ Records of Anchor Medical for January 16, 2014 to June 4, 2014.
- ✓ A medication history.
- ✓ A note dated February 13, 2015 signed by Rex Appenfeller, MD.
- ✓ Hearing testimony.

Medical and other evidence of an individual's impairment is treated consistent with (20 CFR 416.913). The record of hearing was held open for additional evidence from Rhode island Hospital, Dr Choa of University Surgical, the Rhode Island Free Clinic (including diagnostic imaging), and updated progress notes from Dr Appenfeller of Anchor Medical. The appellant was provided with detailed release forms for each treating source. Written instructions and contact information were sent to both parties. At the close of business on May 14, 2015, no new medical evidence records from any source had been received. There was no contact from the appellant to request extension of the deadline to submit evidence. She has allowed the record to close without the inclusion of the missing records which she identified as essential during the hearing.

According to 20 CFR 416.916 (If you fail to submit medical and other evidence): You must co-operate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). When you fail to cooperate with us in obtaining evidence, we will have to make a decision based on the information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

All medical opinion evidence is evaluated in accordance with the factors set forth at (20 CFR 416.927). The existing evidence record consists of 4 ½ months of Anchor Medical records and a note from her primary care physician. Although his note indicates that he has treated her for fifteen years, and his opinions may be justifiable, the limitations expressed lack support of specific clinical and diagnostic details as required by the regulations. There is no acceptable evidence from a specialist, or proof of a treatment relationship of the nature and extent that would justify controlling weight of opinion. All records and testimony are considered in combination for the purpose of the evaluation.

The MART is considered a non-examining source when expressing opinions regarding an individual's condition. At the time of application, the MART reviewed evidence of benign hypertension, low back pain, obesity, depressive

disorder, and generalized anxiety disorder. The MA-63 form completed by her physician was not returned with the application. They were unable to find records supporting physical therapy or pain management. As there was not an active SSI case at the time, they were unable to access consultative examination reports (if any). The available information primarily addressed back pain, and therefore, they were unable to base their evaluation on any other conditions. They opined that that back pain would restrict physical activity to light exertional level work, which did not preclude her from performing her past relevant work experience, and therefore, she was not disabled.

Additional evidence including a note from PCP, Rex Appenfeller, MD, an updated Agency AP-70 form, an Agency MA-63 form signed by Rex Appenfeller, MD, and a medication history list were submitted by the appellant during the hearing. As of the date of this decision, the MART has not withdrawn the notice of denial under appeal. The rationale for their final decision has not been communicated to this Appeals Officer.

The appellant has alleged that symptoms of degenerative disc disease (DDD), spinal stenosis, chronic low back pain, nerve damage secondary to a ruptured Achilles tendon, intestinal prolapse (status post surgical repair), high blood pressure, anxiety, depression, panic attacks, bipolar disorder, ADHD, narcolepsy, sleep apnea, and premenstrual dysphoric disorder (PMDD) impair her both physically and mentally. A private insurer had established that she was disabled according to that company's criteria which assesses ability to perform the job held at the time of the claim, and does not apparently extend to vocational factors of transferability of skills or ability to retrain for other work as required of the federal Social Security regulations. They established an onset of disability on October 2011, and she has not returned to work activity since July 2011. The letter from the insurance company provided for the evidence record does not offer any explanation of what condition(s) were considered disabling.

The available records do not include any mental health evaluations from a psychiatrist or psychologist. As a result, there is no evidence to support the diagnosis of any anxiety-related disorders, affective disorders, or of ADHD, or to establish the impact of any of the alleged conditions on mental functioning. Her PCP has prescribed some anti-depressant and anti-anxiety medications and did respond to mental activity questions when completing the MA-63 form, indicating that he found no limitations to ability to perform basic mental work skills. He also included in his progress notes that memory and mental status were each grossly normal.

The appellant has been treated with medication for hypertension. She was adamant that high blood pressure was a side effect of increased anxiety, as opposed to being a steadily occurring condition. Because hypertension generally causes disability through its effects on other body systems, the record is examined for any limitations imposed by even intermittent high blood pressure to

the heart, brain, kidneys, or eyes. Progress notes describe hypertension as "benign", and show no evidence that it has resulted in any end organ damage, or could be expected to affect functioning. It appears to be effectively medication managed at this time.

In March 2015 surgical correction of intestinal prolapse was completed. There is no follow up information indicating that any limiting symptoms remain after recovery from that procedure. Furthermore, most of the available progress notes and physician forms were completed prior to the surgical procedure. It is not clear what pain she was experiencing as a result of her gastro-intestinal disorder, and what symptoms might be related to other conditions. There are also no clinical evaluations of sleep disorders or PMDD. Narcolepsy, sleep apnea, and PMDD are completely unproven.

She stated that she had sustained an injury to her left Achilles's tendon, which her PCP notes was surgically repaired in 2011. Although she alleges that residual nerve damage exists, there is no specific neurological evaluation, EMG, or nerve conduction testing to support that claim. There is evidence that medications typically used to treat neuropathy have been prescribed, and that she has shown some changes in gait. Records do not establish treatment compliance and effectiveness, nor do they connect the altered gait with the nerve damage as suggested.

Changes in gait, ambulation limited by pain, and limited straight leg raising tests were discussed in the context of evaluation of lumbago complicated by obesity. The appellant had alleged that she had been diagnosed with degenerative disc disease (DDD) based on findings of an MRI. Radiation of pain from the lumbosacral spine to the hips, and into the left lower extremity was documented as a patient complaint more than a year ago. At that time she indicated that she required some help with daily activities. However, six months later, she completed an AP-70 form that indicated that she was able to get around independently, walk about 1 hour per day, cook, do dishes and laundry, vacuum, dust, make beds, and that she required no assistance for personal care such as bathing and dressing. She was able to shop, attend appointments, and visit with friends and relatives. She did indicate that she experienced intermittent periods of exacerbated pain that would limit her for a few days to a few weeks. It appeared that she may have triggered adverse symptoms after trying to move to a new home. While back problems are described as chronic, and have been affirmed by her PCP of fifteen years, information supporting the specific disorder that affects her is very limited. No MRI or other diagnostic imaging reports have been submitted, and evidence is without support for diagnosis of spinal stenosis as alleged. No limits to range of motion, sensation, or reflexes are indicated. Extremities retained normal tone and motor strength, and there was no sign of cyanosis or edema. Treatment did not include any physical therapy, pain management referrals or epidural steroid injections. A referral to an orthopedic surgeon was made early in 2014 resulting in a recommendation that she have a

lumber fusion to relieve pressure on the damaged discs. She understandably wanted a second opinion, but her efforts were delayed, and eventually intestinal prolapse which urgently required surgical repair took priority. No further assessments of a neurosurgeon or orthopedic surgeon have been indicated since January 2014.

In order to get benefits, an individual must follow treatment prescribed by her physician if this treatment can restore her ability to work. If the individual does not follow the prescribed treatment without good reason, she will not be found disabled. The individual's physical, mental, educational, and linguistic limitations will be considered to determine if she has an acceptable reason for failure to follow prescribed treatment in accordance with 20 CFR 416.930. Although the presence of an acceptable reason must be evaluated based on the specific facts developed in each case, examples of acceptable reasons for failing to follow prescribed treatment can be found in (20 CFR 416.930 (c)). The treatment recommended in this situation is a surgical intervention of significant complexity. It is completely appropriate for the appellant to make efforts to obtain a second opinion. Furthermore, although delay based on other medical priorities is a justifiable choice, nearly fourteen months prior to the required abdominal surgery had lapsed without any arrangements to complete a second assessment of the spine condition. She testified that she had had been disadvantaged by extraordinary medical bills incurred during treatment of her daughter's serious condition. Subsequently, she had appeared to have slowed her attempts to address other medical options because of the expense of medical insurance premiums. Her financial responsibility was higher than expected due to her disability insurance income, and she felt she had to make a choice to forego that purchase. Unfortunately, as this evaluation is based strictly on medical facts, and not financial information, a finding of disability would not necessarily result in a more affordable option, as her eligibility for Medicaid could again be impacted by her unearned income.

Symptoms, including pain, are evaluated in accordance with the standards set forth at (20 CFR 416.929). The appellant in this case has alleged that she suffers significant pain secondary to Achilles's tendon injury, and DDD of the spine radiating to the left lower extremity. The evidence record supports that she has been treated with remedies that would typically be used for those conditions, but does not include acceptable clinical and diagnostic evidence establishing the exact etiology of the conditions, relationship to the symptoms described, severity of progression of the conditions, or compliance and effectiveness of prescribed treatments. While pain medications have been prescribed, there is no indication that she has tried physical therapy, chiropractic manipulation, aquatic therapy, epidural steroid injections, acupuncture, heat and cold therapy, or consulted with any pain management specialists. Opinions needed from specialists in neurosurgery and/or orthopedics have been delayed for more than a year.

In general, the evidence and testimony in this case involve several irregularities, some of which might be explained by intermittent and changing symptoms occurring throughout the past 18 months. However, the responding primary care physician has documented surgical repair of rectal prolapse several times, which the appellant states was more correctly identified as "intestinal" prolapse. No records have addressed the post-operative follow up in order to establish the success of that surgery, although that does not seem to be a primary complaint. The physician also repeatedly noted routine treatment for hypertension. Again, she has corrected that information by explaining that she does not have ongoing hypertension, and that increases in blood pressure are associated with anxiety disorder. There are no supportive objective findings for a diagnosis of anxiety disorder, or any other mental health impairment. While the physician has been consistent, the appellant has discredited several of his progress notes.

Additionally, three AP-70 forms completed by the appellant over a span of one year report some significant differences in functional capabilities. In February she indicated that she needed help with several ADLs, but in August responses demonstrated significant independence. It is possible that medical changes and resulting impact on functioning could vary. In order to complete a disability assessment requiring twelve month duration of limitations imposed by a medically determinable impairment or combination of impairments, evidence supporting the various claims is essential, but is lacking in this case. It is very difficult to align allegations of symptoms with actual medically determinable impairments. Example: Vague pain complaints could have been abdominal (and now corrected by surgery), neuropathic (which has not be evaluated), or musculoskeletal (which may be expected to improve with prescribed remedies). It is also not established which of those conditions may impact altered gait or range of motion.

Finally, she has alleged the existence of multiple conditions including spinal stenosis, nerve damage, anxiety, depression, panic attacks, bipolar disorder, ADHD, narcolepsy, sleep apnea, and premenstrual dysphoric disorder (PMDD); which have not been supported by acceptable clinical and diagnostic evidence.

CONCLUSION:

In order to be eligible for Medical Assistance (MA) benefits, an individual must be either aged (65 years or older), blind, or disabled. When the individual is clearly not aged or blind and the claim of disability has been made, the Agency reviews the evidence in order to determine the presence of a characteristic of eligibility for the Medical Assistance Program based upon disability. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

Under the authority of the Social Security Act, the Social Security Administration has established a **five-step** sequential evaluation process for determining whether or not an individual is disabled (20 CFR 416.920). DHS policy directs that disability determination for the purposes of the MA program shall be determined according to the Social Security sequential evaluation process. The individual claimant bears the burden of meeting steps one through four, while the burden shifts to DHS to meet step five. The steps must be followed in sequence. If it is determined that the individual is disabled or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step. If it cannot be determined that the individual is disabled or not disabled at a step, the evaluation continues to the next step.

Step one: A determination is made if the individual is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. Substantial work activity is work that involves doing significant physical or mental activities (20 CFR 416.972(a)). Gainful work activity is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in SGA (20 CFR 416.974 and 416.975). If an individual is actually engaging in SGA, he/she will not be found disabled, regardless of how severe his/her physical or mental impairments are, and regardless of his/her age, education and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

The appellant has testified that she is not currently working. As there is no evidence that the appellant is engaging in SGA, the evaluation continues to step two.

Step two: A determination is made whether the individual has a medically determinable impairment that is severe, or a combination of impairments that is severe (20 CFR 416.920(c)) and whether the impairment has lasted or is expected to last for a continuous period of at least twelve months (20 CFR 416.909). If the durational standard is not met, he/she is not disabled. An impairment or combination of impairments is not severe within the meaning of the regulations if it does not significantly limit an individual's physical or mental ability to perform basic work activities. Examples of basic work activities are listed at (20 CFR 416.921(b)). A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's statement of symptoms. Symptoms, signs and laboratory findings are defined as set forth in (20 CFR 416.928). In determining severity, consideration is given to the combined effect of all of the individual's impairments without regard to whether any single impairment, if considered separately, would be of sufficient severity (20 CFR 416.923). If a medically severe combination of impairments is found, the combined impact of the impairments will be considered throughout the disability determination process. If the individual does not have a severe medically determinable impairment or combination of impairments, he/she will not be found disabled. Factors including age, education and work experience are not considered at step two. Step two is a *de minimis* standard. Thus, in any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on an individual's ability to perform one or more basic work activities, adjudication must continue beyond step two in the sequential evaluation process.

The appellant has alleged she is impaired by chronic back pain; however, there are no test results which verify the current progression of DDD, the existence of spinal stenosis, and radiculopathy; or any other abnormality of the spine. Diagnostic images were discussed, but not submitted, and apparently were outdated. Although it is understood that she was injured several years ago, the disability evaluation requires proof of her condition as of the time of application. The evaluations of specialists have not been made part of the record, and limited attempts to treat pain with methods other than prescription medications have been documented. While continuation of back pain is believable, she has described intermittent symptoms and physical capabilities, and has not proven how her current condition would impact her ability to function, or if it could be expected to continue to do so with compliance to prescribed treatment remedies. There is no substantive information relative the repair of the Achilles's tendon injury or assessment of residual deficits. Intestinal prolapse has been corrected, and no abnormalities are indicated. High blood pressure is medically managed, and has not been associated with any organ damage. No mental health records or other evaluations supporting diagnoses of anxiety, depression, panic disorder, bipolar disorder, ADHD, sleep disorders, or PMDD have been found within the available records.

At step two of the sequential evaluation, the appellant bears the burden of proof. The record, as it exists, reveals that the appellant has not met her burden of proof relative to the requirement to support allegations of disability with acceptable clinical and diagnostic medical evidence. The evidence documented history of back pain, although specific abnormalities of the spine have not been identified and supported. Surgical intervention has been proposed. The records also lack information relative to the additional diagnoses added at hearing as itemized above. The available evidence does not establish that a medically determinable impairment or combination of impairments result in a measurable impact on functional ability. Therefore, the sequential evaluation of disability ends at Step two.

After careful and considerate review of the Agency's policies as well as the evidence and testimony submitted, this Appeals Officer concludes that the appellant is not disabled as defined in the Social Security Act, and for the purpose of the Medical Assistance Program.

Pursuant to DHS Policy General Provisions section 0110.60.05, action required by this decision, if any, completed by the Agency representative must be confirmed in writing to this Hearing Officer.

Carol J. Ouellette
Appeals Officer

APPENDIX

0352.15 ELIGIBILITY BASED ON DISABILITY

REV:07/2010

A. To qualify for Medical Assistance, an individual or member of a couple must be age 65 years or older, blind or disabled.

B. The Department evaluates disability for Medical Assistance in accordance with applicable law including the Social Security Act and regulations (20 C.F.R sec. 416.901-416.998).
   1. For any adult to be eligible for Medical Assistance because of a disability, he/she must be unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted, or can be expected to last for a continuous period of not less than twelve (12) months (20 C.F.R. sec. 416.905).
   2. The medical impairment must make the individual unable to do his/her past relevant work (which is defined as "work that you have done within the past 15 years, that was substantial gainful activity, and that lasted long enough for you to learn to do it" (20 C.F.R. sec. 416.960(b))or any other substantial gainful employment that exists in the national economy (20 C.F.R. sec. 416.905).
   3. The physical or mental impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. The individual's statements alone are not enough to show the existence of impairments (20 C.F.R. sec. 416.908).

0352.15.05 Determination of Disability

REV:07/2010

A. Individuals who receive RSDI or SSI based on disability meet the criteria for disability.
   1. A copy of the award letter or similar documentation from the Social Security Administration is acceptable verification of the disability characteristic.
   2. For individuals who were receiving SSI based on disability and were closed upon entrance into a group care facility because their income exceeds the SSI standard for individuals in group care, a copy of the SSI award letter serves as verification of the disability characteristic.

B. For all others, a disability review must be completed and a positive finding of disability must be made before eligibility for MA based on disability can be established.
   1. In such cases, it is the responsibility of the agency representative to provide the applicant with the following:
      a. Form letter AP-125, explaining the disability review process
      b. Form MA-63, the Physician Examination Report with instructions
      c. Form AP-70, the applicant's report of Information for Determination of Disability
      d. Three copies of form DHS-25M, Release of Medical Information
      e. A pre-addressed return envelope
   2. When returned to DHS, the completed forms and/or other medical or social data are date stamped and promptly transmitted under cover of form AP-65 to the MA Review Team (MART).
      a. If the completed forms are not received within thirty (30) days of application, a reminder notice is sent to the applicant stating medical evidence of their disability has not been provided and needs to be submitted as soon as possible.
      b. If all completed forms are not received within forty-five (45) days from the date of application, the referral to MART is made with the documentation received as of that date.
   3. It is the responsibility of the applicant to provide medical and other information and evidence required for a determination of disability.
      a. The applicant's physician may submit copies of diagnostic tests which support the finding of disability.
      b. The physician may also choose to submit a copy of the applicant's medical records or a letter which includes all relevant information (in lieu of or in addition to the MA-63).

0352.15.10 Responsibility of the MART

REV:07/2010

A. The Medical Assistance Review Team (MART) is responsible to:
   1. Make every reasonable effort to assist the applicant in obtaining any additional medical reports needed to make a disability decision.
      a. Every reasonable effort is defined as one initial and, if necessary, one follow-up request for information.
      b. The applicant must sign a release of information giving the MART permission to request the information from each potential source in order to receive this assistance.
   2. Analyze the complete medical data, social findings, and other evidence of disability submitted by or on behalf of the applicant.

3. Provide written notification to the applicant when a decision on MA eligibility cannot be issued within the ninety (90) day time frame because a medical provider delays or fails to provide information needed to determine disability.
4. Issue a decision on whether the applicant meets the criteria for disability based on the evidence submitted following the five-step evaluation process detailed below.
   a. The decision regarding disability is recorded on the AP-65 and transmitted along with the MART case log to the appropriate DHS field office where the agency representative issues a decision on MA eligibility.
   b. All medical and social data is retained by the MART.

B. To assure that disability reviews are conducted with uniformity, objectivity, and expeditiously, a five-step evaluation process is followed when determining whether or not an adult individual is disabled.
   1. The individual claimant bears the burden of meeting Steps 1 through 4, but the burden shifts to DHS at Step 5.
      a. The steps must be followed in sequence.
      b. If the Department can find that the individual is disabled or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.
      c. If the Department cannot determine that the individual is disabled or not disabled at a step, the evaluation will go on to the next step (20 C.F.R. sec. 416.920).
   2. Step 1
      A determination is made if the individual is engaging in substantial gainful activity (20 C.F.R. sec. 416.920(b)). If an individual is actually engaging in substantial gainful activity, the Department will find that he/she is not disabled. "Substantial gainful activity" is defined at 20 C.F.R. sec. 416.972.
   3. Step 2
      A determination is made whether the individual has a medically determinable impairment that is severe, or a combination of impairments that is severe (20 C.F.R. sec. 416.920(c)) and whether the impairment has lasted or is expected to last for a continuous period of at least 12 months (20 C.F.R. sec. 416.909). If the durational standard is not met, the Department will find that he/she is not disabled.
      a. An impairment or combination of impairments is not severe within the meaning of the regulations if it does not significantly limit an individual's physical or mental ability to perform basic work activities (20 C.F.R. sec. 416.921). Examples of basic work activities are listed at 20 CFR sec. 416.921(b)).
      b. In determining severity, the Department considers the combined effect of all of an individual's impairments without regard to whether any such impairment, if considered separately, would be sufficient severity (20 C.F.R. sec. 416.923).

i. If the Department finds a medically severe combination of impairments, then the combined impact of the impairments will be considered throughout the disability determination process.
ii. If the individual does not have a severe medically determinable impairment or combination of impairments, the Department will find that he/she is not disabled.

c. The Department will not consider the individual's age, education, or work experience at Step 2.
d. Step 2 is a de minimis standard. In any case where an impairment (or multiple impairments considered in combination) has more than a minimal effect on the individual's ability to perform one or more basic work activities, adjudication must continue beyond Step 2 in the sequential evaluation process.

4. Step 3
A determination is made whether the individual's impairment or combination of impairments meet or medically equal the criteria of an impairment listed in the Social Security Administration's Listings of Impairments (20C.F.R. Pt 404, Appendix 1 to Subpart P).
a. If the individual's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement, the individual is disabled.
b. If it does not, the analysis proceeds to the next step.

5. Step 4
A determination is made as to the individual's residual functional capacity (RFC) and whether, given the RFC, he/she can perform his/her past relevant work (20 C.F.R. sec. 416.920(e)).
a. An individual's RFC is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments.
i. In making this finding, all of the individual's impairments, including impairments that are not severe will be considered (20 C.F.R. sec. 416.920(e), 416.945, and Social Security Ruling ("S.S.R.") 96-8p as applicable and effective).
ii. The Department will assess the individual's RFC in accordance with 20 C.F.R. sec. 416.945 based on all of the relevant medical and other evidence, including evidence regarding his/her symptoms (such as pain) as outlined in 20 C.F.R. sec. 416.929(c).
b. It must be established whether the individual has the RFC to perform the requirements of his/her past relevant work either as he/she has actually performed it or as it is generally performed in the national economy.

c. The Department will use the guidelines in 20 C.F.R. sec. 416.960 through 416.969, and consider the RFC assessment together with the information about the individual's vocational background to make a disability decision. Further, in assessing the individual's RFC, the Department will determine his/her physical work capacity using the classifications sedentary, light, medium, heavy and very heavy as those terms are defined in 20 C.F.R. sec. 416.967 and elaborated on in S.S.R. 83-10, as applicable and effective.
d. If the individual has the RFC to do his/her past relevant work, the individual is not disabled. If the individual is unable to do any past relevant work, the analysis proceeds to the fifth and final step in the process.

6. Step 5
The Department considers the individual's RFC, together with his/her age, education and work experience, to determine if he/she can make an adjustment to other work in the national economy (20 C.F.R. sec. 416.920(g)).
a. At Step 5, the Department may determine if the individual is disabled by applying certain medical-vocational guidelines (also referred to as the "Grids", 20 C.F.R. Pt. 404, Appendix 2 to Subpart P).
i. The medical-vocational tables determine disability based on the individual's maximum level of exertion, age, education and prior work experience.
ii. There are times when the Department cannot use the medical-vocational tables because the individual's situation does not fit squarely into the particular categories or his/her RFC includes significant non-exertional limitations on his/her work capacity. Non-exertional limitations include mental, postural, manipulative, visual, communicative or environmental restrictions.
b. If the individual is able to make an adjustment to other work, he/she is not disabled.
c. If the individual is not able to do other work, he/she is determined disabled.

0352.15.15 Evidence

REV:07/2010

A. Medical and other evidence of an individual's impairment is treated consistent with 20 C.F.R. sec. 416.913.

B. The Department evaluates all medical opinion evidence in accordance with the factors set forth at 20 C.F.R. sec. 416.927.

C. Evidence that is submitted or obtained by the Department may contain medical opinions.
   1. "Medical opinions" are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of an individual's impairments, including:
      a. Symptoms
      b. Diagnosis and prognosis
      c. What the individual can do despite impairments
      d. Physical or mental restrictions
   2. Medical opinions include those from the following:
      a. Treating sources - such as the individual's own physician, psychiatrist or psychologist
      b. Non-treating sources - such as a physician, psychiatrist or psychologist who examines the individual to provide an opinion but does not have an ongoing treatment relationship with him/her
      c. Non-examining sources -such as a physician, psychiatrist or psychologist who has not examined the individual but provides a medical opinion in the case

   3. A treating source's opinion on the nature and severity of an individual's impairment will be given controlling weight if the Department finds it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record.
      a. If a treating source's opinion is not given controlling weight, it will still be considered and evaluated using the same factors applied to examining and non-examining source opinions.
      b. The appeals officer will give good reasons in the administrative hearing decision for the weight given to a treating source's opinion.
   4. The Department evaluates examining and non-examining medical source opinions by considering all of the following factors:
      a. Examining relationship
      b. Nature, extent, and length of treatment relationship
      c. Supportability of opinion and its consistency with record as a whole
      d. Specialization of medical source
      e. Other factors which tend to support or contradict the opinion.
      f. If a hearing officer has found that a treating source's opinion is not due controlling weight under the rule set out in the foregoing paragraph, he/she will apply these factors in determining the weight of such opinion.
      g. Consistent with the obligation to conduct a de novo (or new and independent) review of an application at the administrative hearing, the appeals officer will consider any statements or opinions of the Medical Assistance Review Team (MART) to be a non-examining source opinion and evaluate such statements or opinions applying the factors set forth at 20 C.F.R. sec. 416.927(f).

D. Symptoms, signs and laboratory findings are defined as set forth in 20 C.F.R. sec. 416.928.

E. The Department evaluates symptoms, including pain, in accordance with the standards set forth at 20 C.F.R. sec. 416.929 and elaborated on in S.S.R. 96-7p, as applicable and effective.

0352.15.20 Drug Addiction and Alcohol

REV:07/2010

A. If the Department finds that the individual is disabled and has medical evidence of his/her drug addiction or alcoholism, the Department must determine whether the individual's drug addiction or alcoholism is a contributing factor material to the determination of disability; unless eligibility for benefits is found because of age or blindness.
   1. The key factor the Department will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether the Department would still find the individual disabled if he/she stopped using drugs or alcohol.
   2. The Department applies the standards set forth in 20 C.F.R. sec. 416.935 when making this determination.

0352.15.25 Need to Follow Prescribed Treatment

REV:07/2010

A. In order to get MA benefits, the individual must follow treatment prescribed by his/her physician if this treatment can restore his/her ability to work.
   1. If the individual does not follow the prescribed treatment without a good reason, the Department will not find him/her disabled.
   2. The Department will consider the individual's physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) and determine if he/she has an acceptable reason for failure to follow prescribed treatment in accordance with 20 C.F.R. sec.416.930.
   3. Although the question must be evaluated based on the specific facts developed in each case, examples of acceptable reasons for failing to follow prescribed treatment can be found in 20 C.F.R. sec. 416.930(c) and S.S.R. 82-59, as applicable and effective.

352.15.30 Conduct of the Hearing

REV:07/2010

A. Any individual denied Medical Assistance based on the MA Review Team's decision that the disability criteria has not been met, retains the right to appeal the decision in accordance with Section 0110; COMPLAINTS AND HEARINGS in the DHS General Provisions.
   1. A hearing will be convened in accordance with Department policy and a written decision will be rendered by the Appeals officer upon a de novo review of the full record of hearing.
   2. The hearing must be attended by a representative of the MART and by the individual and/or his/her representative.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.